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AND THE CALIFORNIA MEDICAL JOURNAL

ISSUED MONTHLY

APRIL, 1920

O. C. WELBOURN, A. M., M. D., Editor
819 Security Building, LOS ANGELES, CAL.

DEVOTED TO THE
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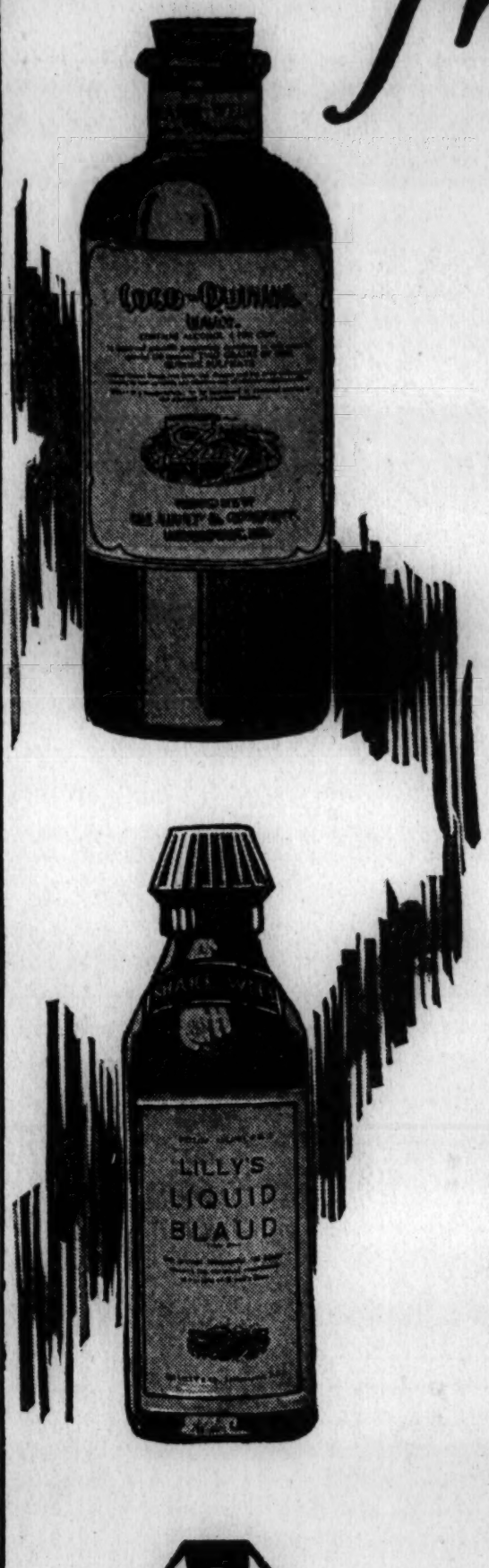
Three Stand-bys



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Retake of Pr

Preceding Frame

SUMMARY OF REPORTS
FROM ONE THOUSAND PHYSICIANS

Remedies named as most useful in INFLUENZA		Remedies named as most useful in PNEUMONIA	
Aconite	788	Bryonia	723
Gelsemium	772	Aconite	617
Bryonia	707	Veratrum	576
Macrotys	384	Lobelia	468
Veratrum	353	Ipecac	411
Eupatorium	328	Asclepias	366
Lobelia	324	Gelsemium	293
Asclepias	268	Belladonna	169
Ipecac	236	Sanguinaria	134

Many physicians found it impossible to name **any** remedy as of "most importance," stating, very truly, that **each** is "most important" when its use is indicated. Others named two or more as most serviceable, giving usually the conditions under which each was used. **For example,** "Gelsemium is most frequently indicated, but where **sepsis** is marked, Echafolta or Echinacea becomes most important." A typical answer, often made, is as follows: "In nearly every case I find indications for **three** remedies—Gelsemium, Macrotys and Eupatorium." Again, "Aconite for fever, Eupatorium for bone-ache, and Macrotys for muscular soreness."

EXTERNAL APPLICATIONS

Libradol	618	Camphorated Oil	62
Compound Emetic Powder	185	Onion Poultice	38
Turpentine Applications	110	Iodine Applications	14
Antiphlogistine	96	Scattering	120
Mustard Applications	72		

Under "Scattering," are included many private prescriptions, as well as such applications as "mush jacket," "flaxseed poultice," "quinine and lard," and one each of the following: "capsicum, mustard and tar," "tobacco and wheat flour," "snuff and black pepper." "Dry cupping" finds one advocate.

It is often stated: "When I cannot get Libradol I use the best attainable substitute," hence many of the above may be considered as emergency applications.

Respectfully,

LLOYD BROTHERS.

Cincinnati, Ohio, March, 1919.

The California Eclectic Medical Journal

Vol. ~~XLIX~~ III APRIL, 1920 No. 4

:: Original Contributions ::

FOCAL INFECTION IN ITS RELATION TO SYSTEMIC DISEASE

T. C. Young, M. D., Glendale, Cal.

Read before the Los Angeles County Eclectic Medical Society

Focal infection in its broad sense may be located in various parts of the body. The one most frequently brought to my notice has been that of the teeth. These foci of infection may be drained by the lymph and blood streams, empty directly into the alimentary tracts, or through fistulous openings into the sinuses of the head.

Focal infection may be primarily a very small and apparently harmless spot in itself, but closely adjacent to areas which are fertile ground or breeding places for various organisms, and then become a secondary infection, which by virtue of its toxic effects produces very severe symptoms.

The teeth may be drained by all three of the avenues by which toxins and bacteria are carried to remote organs, and likewise being in very close proximity to the sinues of the head produce secondary inflammation of the same.

Cases of sinusitis are many times treated for long periods of time with no results. Radical operations performed, still the trouble remains. The patients and physicians are disappointed and become discouraged. One reason why results have not been obtained is that the study of the apices of the teeth in the alveoli by radiograph has been overlooked by physicians, specialists and dentists. This I consider a grave error. I find in my own work as a general practitioner that radiography is very necessary, and would also consider it such in the work of the specialist in eye, ear, nose and throat.

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It seems to me that we have the cart before the horse in a high percentage of antrum and other sinus cases.

If the sinus becomes diseased we should look for a possible focus of infection in some other part of the body that may be producing the disorder. The teeth are to be ruled out first of all, as I have found them the most common contributing factor in such conditions. Take care of the teeth and the sinuses will clear up, turbinates will decrease in size, and nasal passages will clear up without a mutilating operation such as a submucous resection and turbinectomy.

Again, the general practitioner who has cases of kidney disturbances, heart lesions, internal secretory gland disorder, as well as many other infections, should consider the possibility of an infection in some part remote from the area affected. I find the teeth, tonsils and sinuses the most frequent sources of infection.

Dr. Charles Mayo, of Rochester, Minn., on February 7, 1916, made the statement before the Research Institute of the National Dental Association at Cleveland, Ohio, "that 90 out of every 100 probably die of some simple infection, the result of a focal infection, which focus of itself would cause them no trouble. He also referred to the fact that 90% of these primary focal lesions were above the collar bone, and again 90% of these are dental infections."

Other very serious conditions that may arise from this source are myocarditis, rheumatism, neurasthenia, various kidney affections, etc. The primary infection located in a remote part of the body produces no apparent pain, and thus may escape the notice of the average physician. Nevertheless, the toxin passing through the blood stream brings about inflammatory and degenerative changes in various organs through overwork as well as the direct action of the toxins upon the tissues. Then we wonder why our patients develop such grave maladies. It is conceded by all that the above conditions may arise from severe infections, such as acute gonorrhoea, scarlet fever, diphtheria, typhoid fever, etc. These diseases last but a short time, it is true, but overwhelm the organs with toxins while they last. Why is it not a feasible argument that a less severe infection produced by an equally dangerous and detrimental organism—such as the streptococcus viridens and Haemolyticus, staphylococcus, micrococcus catarrhalis, pneumococcus, and other equally pathogenic, isolated in a bony area or sinus with slow drainage, but a continual one, going on for years—would cause as severe affections?

I do not consider it necessary that every general practitioner should be able to treat an infection of the teeth, but I do think it is very necessary that he should be able to recognize when such a condition exists, and either locate the source of trouble or refer his patient to a specialist in that line who is capable of finding the trouble.

I consider dentistry a branch of medicine that everyone who intends to become a physician should be taught, not with the idea of following that line of work, but for general diagnostic purposes.

I always examine the teeth of patients suffering from arthritis, neuritis, rheumatism, etc. If I find crowns, bridgework and fillings where the nerve has been removed with a history of ulceration, I always radiograph them. This, in my opinion, should be practiced as a routine in all the above mentioned cases.

Dr. Oliver T. Osborne, of Yale University School of Medicine, has made the statement that "A root canal filling should never be done until after the patient has been subjected to a careful radiographic examination of the teeth and alveolus." In studying the films one must understand the appearance of normal teeth in normal bone. Radiographs of the normal teeth show simple cancellus bone tissue with the peridental membrane showing as a dark line surrounding the root of the tooth. This dark appearance is due to the fact that the peridental membrane offers little or no resistance to the penetration of the ray. Any tooth in the above condition may be eliminated as a source of trouble. However, if we find a condition of rarification on one side of the root we would suspect an infection from the neighboring tooth. In infections of the peridental membrane we suspect a chronic inflammation, usually occurring from devitalized teeth. I have not found an apical abscess in a vital tooth. This very nearly proves to my satisfaction that the infection is from the pulp canal. You may see a condition in vital teeth with quite an area of rarification around the root of the tooth appearing as though it were a hypertrophy of the peridental membrane. Noticing this tooth very carefully, you usually find a bridge suspended from the tooth with evidence of overwork, or it may be due to the absence of articulation with the opposing tooth, showing loss of function.

I wish next to consider a few case histories which have come under my observation, and have been followed out in a routine manner:

1. Clinical history of patient considered.
2. Xray findings prior to extraction.
3. Inoculation of culture at time of extraction.
4. Germs actually grown and examined under the microscope, and results obtained.

The first case I wish to mention is that of Mrs. L., age 38. Mrs. L. gives a history of neuralgia for short periods (two or three years), occasional inflammation of the left eye and pain in the left cheek. Xray films as shown in the projectascope shows an abscessed condition of the right upper bicuspid, upper incisors, and left upper bicuspid and lower left molar. Was advised after Xray to have these extracted. She refused to do this and allowed the condition to remain. In a few days severe inflammation developed in the left autrum and frontal sinus. After repeated irrigations this was cleared up, extraction was done, patient's symptoms did not clear up; Xray followed, showing evidence of necrotic bone remaining under the right antrum, with extreme inflammation of the mucous membrane of the same. Operation followed, necrotic bone was removed and antrum drained, still patient did not recover. One month later all of the uppes teeth wee emoved and alveoli cuetted. Patient is reported to be in good condition. By this case I wish to show that it is not possible to remove all focal infection by one operation.

Case No. 2. Mr. G., age 45. History of lumbago, general neuritis two years previous, acute symptoms of musculo spiral neuritis of a very severe variety. Xray was taken, showing evidence of pyorrhoea with apical abscess. From the apices and alveoli cultures were made by Dr. A. Goff, laboratory diagnostician, and the findings were staphylococcus, streptococcus and gram positive bacillus fusiformis. Extraction followed. Patient is improving.

Case No. 3. Mrs. S., age 55, gives history of kidney and bladder disorder for 15 years, stomach symptoms for 10 years, sciatic neuritis 10 or 15 years, heart complications 8 or 10 years, headache, high blood pressure, lumbago. These symptoms brought her under my observation. Xray examination followed, showing peri-apical abscesses of the upper incisor, right and left bicuspid, and right and left molar, consequently the severity of the symptoms. All of the teeth were extracted and cultures were maie by Dr. Goff. Findings were staphylococcus, streptococcus and micrococcus catarrhalis. Patient's symptoms after extraction and curretage of alveoli process have cleared up.

Case No. 4. Mr. L., with peri-apical abscess of upper

CASE NO, 1. MRS. L.

Periapical Abscess

After Extraction and Curretment

CASE NO. 2. MRS. G.

Pyrrohœal Pockets

Traumatic Injury from Overwork

CASE NO. 3. MRS. S.

Abscess

CASE NO. 4. MRS. L.

Abscess of Upper Incisors

Filling in of Normal Bone Tissue

incisors and showing various symptoms as stated before, and not wishing to have an extraction, a root amputation was decided upon. This was an absolute success, as is shown in three radiographs following work done.

Treatment of these cases. If the clinical history is that of kidney, heart, internal secretion glands disease, dyspepsia or neurasthenia, and after Xray examination peri-apical abscesses of the teeth are found particularly those of the molar and bicsspids, I consider it necessary to extract the teeth and csrette the alveolis. By this means you may remove all the infected area and clear up any focal infection. Do not understand me to say that it is possible to do this at one operation. I consider it necessary to Xray the case a few days or a week following extraction and curettage, to determine whether or not you have all of the necrotic process. If you have not succeeded in removing the necrotic tissue the first time, it may necessitate three or four efforts to do so. If at the time of extraction of molar or bicuspid you find the floor of the antrum is necrotic, I do not hesitate to open it freely and curette it out and give free drainage. This is the only avenue through which an antrum can be thoroughly drained. In peri-apical-abscesses in cuspids or incisors it is possible to do a root amputation and remove necrotic area and allow a solid tooth to remain. Some results that have been obtained by root amputation I will show you in the projectascope at the close of this paper.

INDICATIONS FOR CESARIAN SECTION

Dr. O. C. Welbourn, Los Angeles

Read before the California State Eclectic Medical Society

Cesarian section is a serious operation and should not be entered into rashly. The pros and cons must be carefully and conscientiously weighed, for there are two lives at stake, as well as the physician's reputation. It is generally conceded that the life of the mother is of greater importance than that of the child; but there may be good and sufficient reasons to equalize or even reverse this rule. Therefore each case should be considered upon its merits.

The indications for cesarian section are divided into absolute and relative and are stated as follows:

Absolute Indications:

1. Impossibility of delivering the fetus even after embryotomy has been performed, caused by a disproportion between

size of birth canal and size of fetus. Such condition may be a deformed and contracted pelvis or an overgrown fetus.

2. Pathological conditions of the mother blocking the parturient canal and impossible of removal caused by uterine and ovarian tumors, stenosis of cervix or vagina, inflammatory pelvic exudates and malignant disease. In the presence of any one of the above conditions a cesarian section is a necessity and should be performed at the earliest possible hour consistent with whatever preparations it is practical to make in a given case.

Relative Indications:

1. Impossibility of delivery without grave injury to mother or fetus, caused by disproportion between the size of the birth canal and size of the fetus; or by mal-position of the fetus.

2. Pathological conditions of the soft parts of the mother, producing obstruction in the parturient canal, the removal of which is equally hazardous with cesarian section; caused by tumors, exudates and stenosis.

3. Eclampsia in the early stage of labor with membranes unruptured and patient in a critical condition.

4. Mal-positions of the placenta, such as placenta praevia centralis or a detached placenta with marked hemorrhage.

In each and all of the obove named relative indications a cesarian section is preferable over any other procedure if the conditions in the particular case are favorable. And the conditions are favorable in so far as the following requirements can be successively met:

1. Asepsis is a prime necessity prior to this operation. Has the patient a prior infection of the genital tract or on the body near the field of operation? Has the patient been infected by a careless examiner, or by dirty surroundings? Have the membranes ruptured? Is the uterus already infected? In the presence of an active infection a cesarian section is contra-indicated.

2. Asepsis is a necessity not only during the operation, but also during the post-operative care. Can asepsis be maintained when attained? Are the surroundings such that it is possible to perform an aseptic major operation? And after the completion of a successful operation can infection be prevented, and the patient carried through the convalescent period?

3. The condition of the patient. Assuming that the patient is free from sepsis, what is her physical condition? Has she any chronic disease? Has she been exhausted by many hours of suffering, possibly on the verge of collapse?

4. A reasonable skill in the operator and his various assist-

ants is required. Each should have skill in his particular task and experience with each other, so that the work of all will co-ordinate. Team work, it is called.

When all of the above requirements are present, success is assured, because it is a typical case. In the presence of an infection, great judgment and skill are required of the operator to decide what operation should be performed. Generally speaking, cesarian section is not advisable. With infection absent but surroundings bad, the difficulties are many but not insurmountable. Eternal vigilance may avoid the many pitfalls. When the patient is in a poor condition much can be done to carry her through the operation, and skillful post-operative care is a necessity. In the the most favorable cases the mortality from cesarian section should be not over one per cent. But we rarely meet such cases, and not infrequently the operator fights a losing fight or gives it up before he begins.

QUININE FOR LEPERS

A letter signed by Sister Louise, a sister of charity who is doing relief work in the far-off leper colony at Tarafangana, Madagascar, has recently been received at the headquarters of the American Red Cross.

"We are in receipt today," she writes, "of the case of quinine which you had the goodness to send us. We hasten to express our deepest gratitude for your generous gift. Our hearts are filled with prayers of gratitude to the good God, who has come so providentially through the American Red Cross, giving us help in time, when the shortage of supplies was hampering our work of charity in this poor mission of Tarafangana."

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Contributions, Exchanges, Books for Review and all other communications should be addressed to THE CALIFORNIA ECLECTIC MEDICAL JOURNAL, 819 Security Building, Los Angeles, California. Original articles of interest to the profession are solicited. All rejected manuscripts will be returned to writers. No anonymous letters or discourteous communications will be printed. The editor is not responsible for the views of contributors.

INFLUENZA IN 1919-1920

The anticipated recrudescence of pandemic influenza arrived according to schedule. At this writing and in this locality it appears to be subsiding and we can at least hope that the worst is over. The mortality rate has been much less than that of a year ago, owing probably to greater skill displayed in its treatment as well as to a less virulent type of infection. The complications also were different. Pneumonia, which was so prevalent last year, was comparatively rare this year, and empyemas were even rarer. On the other hand, disturbances of the digestive tract were much more prevalent this year than last. This complication was frequently found in children and proved to be quite intractable. Many cases suggested cholera infantum. The convalescence was slow and the treatment both tedious and difficult. The digestion and assimilation of a sufficient amount of food to sustain life was a desideratum not easily attained. It was a serious complication. However, the mortality rate was low even in this phase of the disease. With the advent of weather less favorable for its development we may confidently expect that this disease will practically disappear.

CHAULMOOGRA OIL

One of the various therapeutical remedies which have met with ups and downs of popularity and unpopularity in sequence is *chaulmoogra* oil, an oil which is purely Indian in origin and which has been known in this country from time immemorial as a cure for leprosy. The oil is not confined to the treatment of leprosy only, but skin diseases of various kinds are often treated with this oil, which is also largely used for veterinary purposes. The oil has a long history behind it, and its administration as a soluble salt made by boiling the oil with an alkali is spoken of in old books. In Europe, too, the oil has long been used with various results. The wide divergence noticed in the quality and in the efficacy of the oil unmistakably pointed to the use of a variety of oils under the name of chaulmoogra, and in the Indian and Colonial Addendum to the British Pharmacopœia, 1898, the oil derived only from two sources, namely, Gynocardia Odorata and Taraktogenous kurzii, was declared to be genuine. There is another source of this oil. It is from Hydrocarpus Wightiana, a tree which grows in South India. In Squire's Companion to the British Pharmacopœia the hydnocarpus oil used to be called *false chaulmoogra.* In the latest (1914) issue of the Pharmacopœia, only Taraktogenous Kurzii was accepted to be a source of genuine chaulmoogra oil, the other sources having been accordingly discarded. But unfortunately the old designation of "Oleum Gynocardia" was retained, and the sodium salts of chaulmoogra oil, which have been re-introduced by Sir Leonard Rogers and used to be called sodium gynocardate until recently. There has been a good deal of scientific work on this very interesting medicinal oil and a *resume* will be found in page 6 of the brochure published in 1917 by Mr. J. C. Ghosh, late pharmaceutical chemist of the Government Medical Stores Department. For the last four years Sir Leonard Rogers has been assiduously carrying out researches in the treatment of leprosy with chaulmoogra oil, and it will be remembered that in December last he declared the hydnocarpus oil (false chaulmoogra) to be of the same therapeutic value as hitherto assigned to the oil obtained from Taraktogenous Kurzii. This was exactly the conclusion arrived at by Mr. Ghosh in 1917, or perhaps earlier, from a chemical consideration of the varieties of chaulmoogra oil, and one of his suggestions was to change the designation of preparations from "Gynocardate" to "chaulmoograte." These preparations in India are specialties of Messrs. Smith, Stanistreet & Co., Calcutta, who declare that each batch is tested by Sir Leonard Rogers before issue, and who, in their advertisement for November, 1919, changed the designation to

"Hydnocarpate." The change will perhaps be adhered to in future, and will no doubt popularize the hydnocarpus oil, removing the erroneous impression that this variety is false chaulmoogra. In Mr. Ghosh's pamphlet ample proofs by references to oldest Sanskrit texts are given about the hydnocarpus oil of South India being the real chaulmoogra, and from a recent telegram of Reuter to the "Strait Times," announcing that the cure of leprosy consists of a refined chaulmoogra oil, it is confidently anticipated that Sir Leonard Rogers will continue his vogorous researches with this oil instead of sticking to his declaration in the last May issue of the "Indian Medical Gazette," that theer is nothing absoltuely specific against leprosy in chaulmoogra oil products. It is understood that the basis of this declaration is that Sir Leonard found very good results in leprosy from the use of sodium morrhurate prepared in the same way as sodium hydnocapate, and his conclusion was that other unsaturated fatty acids might also be expected to yield effective preparations against the acid-fast bacilli of both leprosy and tuberculosis. He also remarks that such action is not limited to the resistant acid-fast bacilli, thus opening up a vast field of research which may in time yield great advances in bacterial diseases, which constitute such an important part of medical science. It is very striking that, proceeding from an examination of Sanskrit texts on leprosy and chaulmoogra oil, Mr. Ghosh arrive dat a similar conclusion, which is recorded in 1917 as follows:

"There is another feature, namely, the use of fatty food in leprosy and other diseases, which is very characteristic of Ayurvedic treatment. Western physicians now prescribe fatty food in cases of tuberculosis, but the ancient Hindus went further. They not only prescribed butter, which is more easily digestible than any other fatty food, but laid down a number of preparations of medicated *ghee* (clarified butter), which were apparently intended to keep up the health of the patient at a high level without taxing the digestive functions, perhaps also to increase phagocytosis."—Indian Medical Record.

DEVELOPMENT OF A NURSING PROFESSION IN POLAND

Outside of the Catholic sisterhoods the profession of nursing is still practically unknown in Europe. Even the good old-fashioned home or practical nurse of the States does not exist. This seems strange, in view of the fact that the Sisters of St. Vincent de Paul were the first women in history to go

out in the battlefield to care for the wounded, and that it was from the French Sisters of Mercy that Florence Nightingale drew her first inspiration and learned her first lessons in nursing. That America and England have gone so far ahead of Continental Europe in this respect is due to the greater freedom of women in English speaking countries.

Since the war, however, since Europe has had a practical demonstration of what American and English trained nurses have done and are doing, these countries have realized the great value of a trained nursing personnel, and training schools are being opened and hundreds of volunteers instructed.

In Poland there are now over fifty Polish Nurses' Aides who are studying in various hospitals under American direction. When Lieutenant-Colonel Chesley, American Red Cross Commissioner to Poland called for thirty volunteers for a beginners' class, over a hundred and fifty applicants responded, and these beginners are now receiving preliminary training from the chief nurse. It is in this eastern field of the war, where thousands of sick and hungry refugees are making their way back home from their exile in Russia, that the need of nurses and modern nursing methods is most felt at the present time. "The suffering and deaths that have occurred in this locality have emphasized more than anything else the great shortage of nurses," says Mrs. Jokatitis, chief nurse of the Red Cross. "But Poland is wide awake, and the Polish doctors have no foolish old-fashioned ideas about women. They are all for modern ideas and progress."

Indeed, the enthusiasm of the Poles over American ideas is unbounded, and the speed with which Polish girls of the best type are being recruited for the work is extremely encouraging. "I wouldn't be surprised to see Poland become the center of woman's activity in Europe," commented Mrs. Jokaitis. "This country gives promise, in many ways, of being a 'second America' once she gets on her feet. And the women of Poland will have a big share in getting her there."

NO MORE RABIES IN POLAND

One of the cuirous results of the war in Poland has been the almost complete disappearance of rabies. Owing, presumbaly, to the large number of wolves and the many semi-wild dogs, rabies was a very common disease five years ago. The Pasteur Institute in Warsaw, which was opened by Pasteur himself, and was the second Pasteur Institute in the world, is said to have given more inoculations than any other institute. But when the

American Red Cross first visited it, to offer what help it could, they found only one doctor and only one patient. The building had been stripped by the Germans, but neither the doctor nor the patient seemed to take the lack of equipment very much to heart.

"You see," the doctor explained, with a smile, "we don't have very many mad dog cases now, because the Germans ate up all the dogs.

Dr. Placida Gardner, chief laboratory expert of the Red Cross in Warsaw, told in a recent interview of the damage done during the German occupation to the Warsaw hospitals, which were formerly well equipped.

"The German soldiers seemed to take special delight in wrecking hospitals," said Dr. Gardner. "After they had stripped the building of everything, even to the electric wiring, the water pipes, the faucets, the door-knobs, they would stand in the middle of a room and literally shoot the place up from floor to ceiling, riddling it to splinters.

"It is not generally known that in the outlying districts of Poland, on the eastern frontier, the German military did not evacuate at the signing of the armistice, as they did from Warsaw and the more western sectors. They remained in possession for nearly six months afterward. They were in Boalystock in March. We came right on their heels. And they had employed their time in wrecking and stripping the country. It is said that before they left they shipped out over a thousand carloads of loot. Much of that was valuable hospital and laboratory equipment, the loss of which resulted in innumerable deaths among Polish soldiers, who, when we came were lying by the hundred in the coagulated blood of their wounds, without bandages, without clothing, without even beds or bedding, except straw or old newspapers—when straw or newspapers could be secured."

In restoring the wrecked hospitals and caring for the sick and wounded behind the fighting line, in fighting typhus, the American Red Cross has done a tremendous work. "But the work has only begun," says Dr. Gardner. "The unusually early winter brings a cry from all over the land for help to fight disease. Between the depredations of the retreating Russians and the incoming and outgoing of the still more pitiless Germans, Poland has been left practically powerless to make the fight alone."

PARALYTIC DEMENTIA

Theodore Davis Adlerman, A.M., M.D., Brooklyn, N. Y.

In bringing this subject to your notice, gentlemen, I have no apology to offer for taking up your time, even if this malady does not interest you; as, in my estimation, progressive general paralysis, or paretic dementia, as it is sometimes called, should be known to every general practitioner, and also because this form of insanity has for every one an interest which is possessed by no other disease. There is no other cause of death among the insane which is so common, and there is no other disease which raises so much controversy as to its cause and pathology.

In all my articles written till now I have not dwelt much on the history of any disease I described, considering it of secondary importance, and if I will now mention only that Boyle and Calmeil (1826) gave the first clinical description of general paralysis, that Klippel, Mieckle, Mott and Campbell and Zacher all did good work in their respective lines in this disease, it will suffice for the present as to the history of paralytic dementia.

Now, what is paralytic dementia, and what do we understand by it?

First, let me tell you that it is a common disease of the superior and lateral convolutions of the brain, which gradually extends over the whole nervous system, producing a peculiar impairment of motor power, and accompanied by insanity. It is a disease which demands a very heavy quota from the educated classes; it is a progressive disease or degeneration, occurring most commonly in married men of middle age, living in the cities, taking both meat and alcohol an dexerting their reproductive functions.

Unlike other forms of insanity, it especially attacks men, and, strange to say ,it attacks men healthy and vigorous, in the prime of life, and not the weakly neurotics.

Will it surprise you, gentlemen, when I tell you that about one-tenth of all patients committed to the insane asylums are general paralytics?

In most patients the beginning of the disease falls in the period between the thirtieth and fiftieth years, and the disease is much rarer in advanced life. The progressive character of the ailment is marked by three stages—the prodrome, the acute and the terminative.

In young people under twenty very few cases have been observed, and the few that have been reported almost always were victims of hereditary syphilis and marked alcoholism in both

parents; and here it will not be out of place to say that by far the most important casual factor of this disease is a previous syphilitic infection, and such an infection can be made out in about 75 per cent of all cases.

Many of you will perhaps say that general paralysis of the insane is not sufficiently uniform to deserve a name. And while we will admit that, in some respects, you cannot look upon general paralysis as a very definite disease, yet the largest number of the insane who suffer from general paralysis present well-marked and typical features. The only thing to remember, though, is that symptoms and courses of each case of general paralysis will vary very much, and depend on the hereditary qualities of the patient, on the proximate causes of the disease, and on conditions under which the degeneration has taken place; and also that a great part at least of the symptoms of general paralysis are purely of a physical nature. And here I would like to add that these symptoms of general paralytics who own a neurotic heredity differ in the course of their disease from those who have no such heredity, and that the disease which depends on syphilis alone differs from that which results from syphilis and trauma or syphilis and alcohol.

With all above said, we can accordingly say that general paralysis is a disease which may attack the most diverse portions of the whole central nervous system—the brain and spinal cord—at the same time or successively; that it begins most frequently in those regions of the cerebrum which have an immediate relation to the regular course of the psychical and certain psycho-motor processes, and that mental and motor symptoms form the introductory features of the disease in a great many cases.

Putting aside, for the present, the ill-marked, anomalous and pseudo-paralytic cases, we will consider the ones we most commonly meet.

Like everything else, it has a beginning and an end, with some different stages which show the different advances of the disease.

This general paralysis usually begins either as the result of local injury or local strain, and will begin in the last developed and most specialized parts of the nervous system.

The first stage may vary much in duration, and, looking back, friends of your patient will remember certain alterations in the man, not much thought of at the time, but which account for certain odd and eccentric things done by him, so that those early symptoms whose nature was at first not recognized ought to have been regarded as initial symptoms.

You will hear about this time, also, that the patient's ordinary

mental work no longer goes on as easily as before. His memory is rather uncertain, and there are well-marked forgetfulness and inattentiveness, which were previously quite impossible for him to exhibit.

The patient becomes often disorderly in his dress, and violates the ordinary rules of decency and morality; he wastes money, commits crimes, is dissolute. He is regardless of propriety, honor and honesty; will run after women, and do this in a very foolish way, not caring for consequences, person or place.

Loss and defect in power of attention is also very common here. Loss of will-power, doubt and uncertainty may simulate neurasthenia, and increased irritability, change in temper and abnormal susceptibility to the influence of stimulants of all kinds are of very frequent occurrence. Hysteria and nervousness also occur long before any danger is suspected, and intellectual degeneration is noticed equally.

In this, by the way, there is a great contrast between general paralytics and those suffering from ordinary mania. The latter are mostly acute, and will defend their acts very skillfully, while the former cannot argue, and generally deny they have done anything that you tax them with.

Another important symptom here is the abnormal irritability. The patient easily becomes agitated, or gets angry on the slightest provocation, and it is from this point that we hear from those surrounding the patient or those nearest to him, "that he is so different from what he was." Sleep, digestion and appetite are much disturbed, and it is here that the general practitioner always makes the same mistake when such a patient presents himself—he treats him for neurasthenia.

The patient becomes unfit for his business or his profession, and what he undertakes he mismanages. His loss of attention and memory is noticeable, and he forgets what he has done a day or two previously, and to me these particular symptoms always brought to my memory certain indications and symptoms of senile dementia, but which, occurring in men of thirty-five or forty years, certainly show the advance of this great disease, paralytic dementia.

Among the sensory warnings, we meet with defect in smell, sudden loss of sight of a temporary kind, loss of hearing, temporary and local anesthesia, hallucinations or illusions of one or more of the senses.

Giddiness and so-called congestions of the brain may occur, ending in vomiting and fainting fits. The patient will himself notice here his mental capacity and memory are diminished, and he becomes anxious on this account.

He notices a feeling of confusion in the head, a peculiar distinct pressure in the head, and here you will also find the patient is unable to reckon, and makes the greatest mistakes in simple examples in multiplication.

On the motor side there is a well-marked restlessness and occasionally stupor or undue torpor, with well-marked sleepiness, slight and temporary aphasia or loss of power of expression by speech or by writing, or other defects of the kind may occur with some alteration in gait; while in some there may be little to notice in the gait or muscular power. And here, on the strength of a few such cases, fault has been found with the term general paralysis as not being applicable to persons who are active on their legs and strong in arms; but this strength is only apparent, and we may at the same time see in these particular cases that the deep reflexes are abnormal, and the earliest phenomenon is an exaggeration of the knee-jerk, which exaggeration, as the disease advances, will give way to a sluggish state and by degrees to a total absence.

Here, again, we must call your attention to another important point—the condition of the pupils. You will find they are often unequal and show particular reflex immobility in a large number of cases, especially in those in which other tabetic symptoms develop. Transitory ocular paralyses are in certain cases early symptoms. The association of reflex immobility of the pupils with an increase of patellar reflex is quite frequent. The ocular changes and visual disturbances are, in my opinion, of great diagnostic value. In a great many cases I observed a conjunctival catarrh, which, aggravated with the general paresis, was characterized by bluish discolorations of the conjunctiva, absence of ciliary limitation, and quite a pronounced resistance to therapeutic measures. In some cases the pupil reacted freely to light and very feebly in others. Color perception suffers with the progression of the paralysis, the perception of violet first disappearing, then blue, and lastly red. In quite a number of cases it is restricted concentrically for white colors.

When I spoke before about the peculiarity of gait I also ought to have added that there may be a dragging of one leg even when the reflex is exaggerated, this depending on one of the convulsive seizures which occur often, or on spinal change. Besides dragging of the leg, the leg is being jerked and not moved steadily, and if the eyes are closed the patient cannot walk, turn around or stand with the heels together. I have also found in these cases quite an unusual manifestation—a voice speaking from within, not heard through the ears—and in these cases this

hallucination seems to have been closely associated with spasmodic contractions of the masticatory muscles.

Besides these local or special troubles, there is often a general indescribable change; the person is not himself, so to speak—he is tending away from himself.

A very good plan in order to recognize the beginning of the symptoms is to have the patient pronounce a few difficult words, such as "artillery," "electricity," "Mars," etc., and you will now always hear "artrallariory" instead of "artillery," "Marsaturr" instead of "Mars," and like blunders.

In the later stages of the disease the speech in many cases is almost entirely incomprehensible. Another peculiar "want of fixity," as I call it, is also shown by the non-recogniiton of time, and by the manner in which violent passion is suddenly changed into amiability. To the same cause may probably be traced the characteristic facility of disposition of the general paralytic, for even at this early stage there are indications of the optimism which as the case progresses, afford a remarkable psychical symptom. The morbid vanity, general exaltation, and the tendency to regard all things in the brightest possible light, are distinctly characteristics of the prodromal stage.

The acute stage of the disease is ushered in by delusions of the wildest character. The patient believes himself to be in possession of millions of money, to be a great genius. All his ideas are expanded and exalted, whether it relates to time, space or personal attributes.

The patient here shows perfect content with himself and all around him, by constant use of superlatives. Everything is all right, splendid, first-rate, fine, superb, etc. This, however, is not in all cases, and the delusion of grandeur is not always an invariable symptom. In many cases the initial melancholic, hypochondriacal conditions prevail. The patient claims he can no longer eat; that he is poisoned; that he has lost his head, arm; that he is very small, etc. In other cases, again, there are states of violent excitement, in which the patient raves loudly, cries, and tries to destroy whatever comes in his way. Finally, we see cases also (very frequent ones) where the patients in their mental relations present simply the symptoms of a mental enfeeblement, slowly increasing to complete dementia, without even showing in any notable form states of excitement or delusions, etc.

A very prominent symptom, in my estimation, is the absence of the ulnar reflex in many cases, and I think it is a symptom of quite some diagnostic value.

There seems to be considerable difference in the sexual power of general paralytics as well as in reflexes. Some lose all sexual

desire or power at a very early period. Others show great sexual excitement, and worry their wives or run after strange women; in confinement they will indulge in constant masturbation, and their conversation is erotic, with hallucinations or delusions of sexual character.

We must not forget here to mention another peculiarity of this disease—the handwriting. We can often detect this peculiarity in a letter otherwise coherent and rational. It is not mere tremor in the formation of the letters, but the writing is blotted, dirty, words left out, letters and syllables missing; a marked want of attention seems to prevail in the letter.

Paralytics may sleep but little, but sleep is not altogether absent.

They generally take food well, often voraciously, and only in few cases do they refuse it. If they conceive a delusion about its being poisoned, it does not last long, and is soon forgotten in the absence of a memory, which is a characteristic of the disease, and this is one reason why the delusions are so constantly changing.

The whole duration of the disease is in some cases only a few months, usually two to three years, and sometimes much more. The most fatal form is that in which there is a very marked emaciation and rapid loss of strength, as a result of the constant unrest and the refusal of food.

Pathologists are not yet agreed whether the essential morbid condition in general paralysis is inflammatory or degenerative; whether the changes occur first in the nerve elements, the stroma or the lymph and blood-vascular system.

It seems to me more than probable that the beginning of the disease is to be found in some alteration of the blood supply, followed by a peri-arterial lymph growth, disturbances of the lymph currents, with consequent malnutrition of the nerve structures, degenerative changes; and then, when the nerve elements begin to atrophy and disorganize, an overgrowth of the spider cells, with other fixed cell proliferation among the degenerating tissues. Then follow the serous, sanguineous apoplexies and other symptoms found.

Considering the great difficulty of an accurate microscopic examination of the brain, it is not strange that our pathology of general paralysis is somewhat defective.

The anatomical affection in general paralysis is by no means limited to the cerebral cortex. We can often make out the loss of fibers in the deeper parts; also in the white substance and the central ganglia.

The changes in the spinal cord must, of course, also be

mentioned here, and they consist in a systemic degeneration of the lateral or posterior columns.

Time and space will not permit me to go more deeply at present into the pathological question of general paralysis.

It is not always possible to distinguish between general paralysis and some other form of mental disorder. Each stage of the disorder has its difficulties.

The diagnosis of beginning general paralysis is of greatest importance, and to establish the existence of the disease we must prove the presence of both bodily and mental symptoms, which on the whole are progressive. To arrive at an undoubted decision at one interview or inspection is very often impossible, and yet it is this which we may be called upon to do.

Patients are certainly sent to asylums as general paralytics by medical men who certify them as insane on account of their extravagant delusions, after seeing these patients only once, and not having examined them carefully. Remember that when you examine non-paralytic patients, under the excitement and strain of your scrutiny they produce symptoms similar to general paralysis. Alcoholic disorders will often produce similar symptoms.

In making a diagnosis the previous history of the patient is of the greatest importance. Remember, also, that chronic alcoholism resembles the second stage of general paralysis in many ways, but, as a rule, there is more evident loss of recent memory in the alcoholic than in the general paralytic. We must, also, not forget to mention here the certain cases of multiple sclerosis and cerebral tumors, both of which show a type of disease very like general paralysis.

Convulsions of kidney disease are often mistaken for general paralysis, and in some cases of alcoholic kidney disease dementia may have been slowly coming on before the fits, and difficulty may thus arise. But if you will remember that albuminuria is rarely met with in general paralysis, the rest is easy.

I must also say here that, in my own experience, I have not found the exalted delusions which characterize general paralysis in patients suffering from alcoholism. The emotional state was one of depression rather than exaltation in all these cases.

The connection between syphilis and general paralysis deserves a few more words. Syphilis is a common cause of general paralysis, and the affinities between some cases of brain syphilis and general paralysis need no further description from me. But there is one point I do want to bring out here, and that is that in syphilitic brain disease, apart from general paralysis, we can do good by specific treatment, but in general paralysis this treatment fails.

Ont of one hundred cases of general paralysis admitted to the asylum at Helsingfors, syphilis was present in seventy-seven men and four women, and was probably present in the other nineteen cases. The interval between the beginning of syphilis and the general paresis was from five to fifteen years. Obecke, Christian and Tetige found syphilis present in ninety-six out of one hundred and thirty examined.

Disseminated sclerosis is often mistaken for general paralysis, but the peculiar staccato speech, the more jerky movements and the slow progress should be borne in mind in differentiating the two diseases.

As I have already taken up quite some of your time, I will only mention here that paralysis agitans, sunstroke and epilepsy may often give rise to a great many of the symptoms of general paralysis, but then you must remember the epileptic fits pass, leaving no paralysis, while in general paralysis the parts are paralyzed or enfeebled for some hours, or even days after; that the epileptic fit leaves the patient without mental deterioration, while in general paralysis the patient is very quiet, no matter how exalted he was before the fit.

The prognosis of general paralysis is rather unfavorable. At present we know of a very few recoveries, and those even are rather doubtful and should be viewed with suspicion. I will not say that no case of general paralysis ever ends in recovery, but it seems to me to be rather rare. What we do obtain and accomplish is to get a remission or temporary recovery, so to say, and the more acute the onset the greater the prospect and longer remission the patient seems to get, and it is very seldom that you will get more than two remissions to occur in any case.

The treatment of general paralysis may be divided into general and special.

First of all, the patient must be removed from all physical and intellectual exertions, as well as from mental excitement—you must get him away from his business. His method of life and diet must be regulated, and here the consideration will come up whether the patient can be properly treated at home, or if he should be removed to some asylum. Whether treated at home or not, the patient must be separated from his nearest relatives, and complete rest and seclusion insisted upon.

As you probably know, general paralytics can be divided into two classes—those with a quiet dementia and those who are subject to paroxysms of blind, imbecile fury and violence. These latter require safe rooms with guarded windows and doors, and protected grounds to exercise.

Specific medical treatment has made but little progress as yet

in this disease. Hyoscyamine, hyoscine, hydrobromate of cicutine (obtained from conium maculatum), belladonna, cannabis, rhus, paraldehyde (insomnias), and ergotin, all have their respective places, indications and uses. Anti-syphilitic treatment can be tried in some cases. Counter-irritation along the spine is of use. Tepid baths with cold sponging, and application of galvanism to the head and spinal cord, gives some results. I need not, of course, mention here the indications for chloral and the bromides, the use of which I always supersede by the administration of veratrum and physostigmine.

Our aim in this particular disease, as long as we cannot cure absolutely, is to bring around a prolonged remission. I am not in favor of soaking such cases in iodide of potassium, and to salivate them with mercury, as I have seen cases sink rapidly under these two drugs, and I never yet saw a patient cured by the anti-syphilic treatment.

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—*National Quarterly.*

SOCIETY CALENDAR

National Eclectic Medical Association meets in Atlanta, Ga., June 15-18, 1920. O. F. Coffin, M.D., Indianapolis, President; Dr. H. H. Helbing, St. Louis, Mo., Secretary.

Eclectic Medical Society of the State of California meets May, 26, 27, 28, 1920, in Fresno, Cal. Ira Wheeler, M.D., Fresno, Cal., President; H. T. Cox, M.D., Los Angeles, Secretary.

Los Angeles Eclectic Medical Society meets at 8 p. m. on first Tuesday of each month. P. M. Welbourn, M.D., Los Angeles, Cal., President; C. Ohnemuller, M.D., Los Angeles, Secretary.

Southern California Eclectic Medical Association meets in October, 1920. Dr. Clinton Roath, Los Angeles, President; Dr. H. C. Smith, Glendale, Secretary.

NEWS ITEMS

Born: To Dr. and Mrs. Fred Bantum, Pasadena, California, on Christmas morning, a son.

Dr. John M. Cleaver has changed his address from Bradbury Building to 317 Exchange Building, Third and Hill Streets, Los Angeles.

Died: Dr. E. R. Petskey, Phoenix, Arizona, died February 22nd following one week's illness with erysipelas. Dr. Petskey had just opened new offices, specializing in veneral diseases and tuberculosis. Mrs. Petskey wishes to sublet these offices.

Prof. John Uri Lloyd, Cincinnati, has been elected recipient of the second Remington Honor Medal. The medal will be presented at a dinner of the New York branch of the American Pharmaceutical Association to be held in New York during April. This gold medal is awarded annually to the man or woman who has done most for American Pharmacy during the preceding year or whose efforts during a number of years have culminated to a point during the preceding year where the result of these efforts would be considered as being the most important and advantageous for American pharmacy. This is a great honor to Prof. Lloyd and we extend our heartiest congratulations.

LINGERING COUGHS

About this time of the year patients make demand upon physicians for relief from chronic coughs that have persisted throughout the spring months, and are the remaining symptom of a severe bronchitis or attack of influenza of the winter.

The logical plan of treatment is to make an effort to raise the general resistance and at the same time offer to the irritated bronchial mucosa an agent that will have a soothing effect. For this double purpose Cord. Ext. Ol. Morrhuae Comp. (Hagee) will prove of marked usefulness, owing to its power to increase bodily strength and its specific action upon bronchial tissues. The regular administration of Cord. Ext. Ol. Morrhuae Comp. (Hagee) is of the utmost service in these chronic coughs, and with many physicians it is a routine measure. Its reconstructive properties make it decidedly valuable in run-down states, an underlying condition in most cases of chronic bronchitis.

CLUB RATES

The various Eclectic publishers have decided to renew their special club offers to December 1, 1918, on a straight 10 per cent reduction, where two or more journals are ordered at one time. If you are not familiar with any of these journals, samples may be obtained on request.

	Price.	Club Rate.
California Eclectic Medical Journal, 819 Security Bldg., Los Angeles	1.00	.90
Eclectic Medical Journal, 630 W. 6th St., Cincinnati, Ohio	2.00	1.80
Ellingwood's Therapeutist, 32 N. State St., Chicago, Ill.	1.50	1.35
National E. M. A. Quarterly, 630 W. 6th St., Cincinnati, Ohio	1.00	.90

You may subscribe to any or all of the above journals through this office, the only condition being that subscriptions are paid in advance and 10 per cent discount allowed on an order for two or more, including this Journal.

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In cases where an anodyne of prompt and definite power is wanted and particularly where the physician is eager to protect the patient from the psysical influence of a hypodermic injection, no more useful agent is at his command than Papine (Battle). Papine is a powerful anodyne, a well balanced formula and prepared from the purest of drugs. Its opium content fortified by other sedatives, insure the patient getting the desired results. Given in this form the possibility of drug addiction is reduced to a minimum, and the care with which Papine's constituent drugs are chosen and compounded gives a high degree of protection against the untoward effects of anodynes.

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